Equitable training equals equitable care: cultural competency training of healthcare providers for sexual minorities

Abstract

Background: The hierarchy of the American medical system and its disconnect of recognition beyond the binary of sexual minorities has created systematic inequitable care because of lack of appropriate cultural competency training. Healthcare providers are not adequately taught appropriate cultural competencies in standardized academic training. Given an online survey of varied health care providers (N=208) who have had direct contact during service delivery with patients in a health care setting within the past six months, the research examined “culturally competent health care delivery,” knowledge, stage of change; pre contemplation, contemplation, preparation, action, maintenance; as per the work of Prochaska & DiClemente, for taking action to be culturally sensitive, culturally competent, culturally appropriate, and future training desirability.

Keywords: healthcare providers, cultural competency, equity, health disparities, men who have sex with men (MSM), sexual minorities, lesbian, gay, bisexual, transgender (LGBT)

Introduction

The health, social, and political goals of Healthy People 2020 address the lesbian, gay, bisexual, and transgender (LGBT) population, while specifically seeking to improve their health, safety, and well-being (United States Department of Health and Human Services). Note the manner in which the Department of Health and Human Services’ Healthy People 2010 called for the elimination of health disparities among lesbian, gay, bisexual, and transgender populations, while also using the term sexual minorities.

Healthy People 2020 defined a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion”.

According to the institute of medicine the following has been asserted:

Lesbian, gay, bisexual, and transgender (LGBT) individuals experience unique health disparities. Although the acronym LGBT is used as an umbrella term, and the health needs of this community are often grouped together, each of these letters represents a distinct population with its own health concerns. Furthermore, among lesbians, gay men, bisexual men and women, and transgender people, there are subpopulations based on race, ethnicity, socioeconomic status, geographic location, age, and other factors. Although a modest body of knowledge on LGBT health has been developed, these populations, stigmatized as sexual and gender minorities, has been the subject of relatively little health research… (p. 18).

Research suggests that LGBT individuals face health disparities linked to social stigma, discrimination, and denial of their civil and human rights. This includes a lack of equity in health care service delivery by health care providers, despite the goal of equity in health for all. However, the discomfort and lack of knowledge they identify on the part of providers, and the hesitancy of patients to engage in disclosure (i.e., patients feel uneasy confiding in someone who is experiencing discomfort and appears to lack knowledge and skills) may also be approached from the perspective of the need for cultural competency training targeted to providers. For example, Brotman, Ryan, and Cormier have recommended educating health care professions “as an important way of raising awareness and improving services” (p. 198).

There have been numerous efforts to provide guidelines for service delivery for healthcare professionals to follow. For example, in a systematic review of current guidelines from 11 sources representing 5 countries for the primary care of lesbian, gay and bisexual people, emergent principles and guidelines were provided, as follows: Principles on (1) cultural competency, (2) equity and human rights, (3) awareness of the population; and, Standards/Guidelines for (1) creating an inclusive clinical environment, (2) clinician-patient communication, (3) documentation, (4) special knowledge for cultural awareness, (5) staff and training, and (6) population health.

“Most of the guidelines reviewed made general statements pertaining to the LGBT group as a whole, rather than highlighting specific health care needs according to sex, diverse expression of sexual orientation, socioeconomic status, age and ethnicity.”

More specifically, there has been a call for the delivery of culturally competent care, evaluation, and research for the lesbian, gay, bisexual and transgender population. ”Boehmer noted that in the past twenty years mentioned groups of individuals have not been appropriately included in public health research. Available research suggests how LGBT communities may avoid routine healthcare, while also commonly reporting dissatisfaction with health care services.

All of this brings us to the conclusion that there is a rationale for
focusing on cultural competence training for health providers. This includes an emphasis on communication and interviewing skills. Currently, the medical providers receive less than five hours of LGBT diversity training. Thus, there is a rationale for asking health care providers for the number of hours that they have received on cultural competence training.

More specifically, Potter et al., indicate how education must address three domains of attitude, knowledge, and skills. “All three domains need to be addressed to achieve maximal competence” while clinicians must strive to “examine their attitudes, increase their knowledge, and enhance the skill with which they provide care to LGBT patients” (p. 11). This was the rationale for asking health care providers about their knowledge and ability (skill) when it comes to enacting their treatment of LGBT and MSM populations using recommended principles, strategies, and guidelines for delivering culturally competent care. In addition, there is a rationale for ascertaining their attitudes about the importance of the education of future professionals covering the recommended principles, strategies and guidelines for delivering culturally competent care.

There are many issues that might be covered in cultural competence training that might explain why LGBT and MSM patient populations tend not to engage in self-disclosure. For example, racial and ethnic minorities may not feel comfortable with labeling themselves as lesbian, bisexual, gay, or transgender, terms historically identified with White culture. There may also be factors of internalized homophobia operating. Internalized homophobia has been defined as the underlying belief that “heterosexuality is the natural/normal/acceptable or superior form of sexuality”. There are also references to the “self hatred that occurs as a result of being a socially stigmatized person”. Furthermore, there have been reports of negative and distressing thoughts and feelings being expressed by lesbians and gay men about their sexuality-feelings which are attributed to experiences of cultural heterosexism and victimization.

Other issues that need to be covered in the training of health care professionals include medical decision authority for same-sex couples. Youth LGBT issues are also important for as a special focus in the training of health care professionals. For example, LGBT individuals are coming out at earlier ages and turning to their clinicians for support; hence, the need for primary providers sensitized to sexual and gender minority health concerns. At the other end of the lifespan continuum, there are special concerns regarding LGBT elders, including accessible eldercare, free of discrimination.

There is also justification for considering the needs of LGBT and MSM patient populations in terms of culture and the resultant need for cultural competence specific to these populations. Historically, there has been a failure to seriously explore and define men’s and particularly gay men’s health as a personal, cultural, and social phenomenon. In addition, the case can be made that not only gay men, but also the larger LGBT and MSM patient populations, may experience both a culture and lifestyle.

There is a rationale for this study in developing a new survey that permits healthcare providers to respond to principles and standards/guidelines for delivering healthcare to LGBT and MSM patient populations. The creation of a new survey is justified by the work of researchers who asserted that their systematic review produced a degree of evidence-based clinical guidelines for primary care clinicians working with the LGB population, while recommending that specific recommendations be targeted to sub-groups, including the transgender. The resultant new survey includes some specifications of the sub-groups for which particular standards/guidelines are applicable (i.e., lesbians, transgender, LGBT youth, etc.).

The Stages of Change theoretical model, also known as the Tran theoretical model, developed by Prochaska and DiClemente and Prochaska and Velicer attempts to synthesize the process of behavior change. Precontemplation, Contemplation, Preparation, Action, Maintenance, and Termination are the six main stages of the theory. There is also evidence that exposure to brief online interventions may result in movement across stages of change. Thus, there is a rationale for conceiving of a new survey developed for this study as potentially serving as a brief online intervention. It is possible that study participants may move across stages of change (i.e., from Precontemplation to Contemplation, or from Contemplation to Preparation) as per the stages and theory of Prochaska and DiClemente. Hence, stages of the change theory have partially framed the study.

Therefore, there is a rationale for cultural competence training for health care professionals focusing on how stress in the social environment induced by rejection, stigmatization, discrimination, and violence has a negative impact on health for LGBT and MSM patient populations.

The ongoing health care issues for lesbian, gay, bisexual, transgender and intersexed patient populations in the United States have been documented by Johnson, et al. The body of research-reviewed data from 1993 to 2002 included issues pertaining to access to care, utilization of care, training of medical and mental health providers, and appropriate preparation of clinical offices and waiting rooms. The same basic needs required for the general population are needed for sexual minorities, in addition to specialized care and attention to detail in regards to acknowledgement, discrimination and stigmatization.

The past twenty years have noted a dramatic increase of social and political awareness for LGBT populations, with increased perspective on the best evidence-based practices of care. As noted, the Lesbian and Gay communities have seen increased highlight, while the Bisexual communities have remained hidden, and “particularly for transgender and intersex populations, the state of research describing their healthcare needs is in its infancy, and much remains to be done to design effective medical and mental health programs and interventions”.

Shavers, et al. examined the overall review of the scientific literature on the current state of racial and ethnic discrimination in the receipt of healthcare. They specifically looked at the measures used to capture the discrimination, prevalence of discrimination, trends over time incorporating both perceived and received, the inverse relationship of discrimination affecting health and the institutional role affecting discrimination. Their results proved the lack of evidence and systematic oversight to capture the weight of discrimination and the strength of methodological approaches for future research. The categorization of discrimination can come from a number of intentional and unintentional factors. Discrimination is pervasive, often intuitional and hidden within the “unassuming” contexts of “policies, practices, structures and regulations”.

Lurie researched the training needs of healthcare providers related to the treatment and care of transgender patients in New York City.
England. The biggest issue reported by the survey sample was the discomfort with asking questions or simply “fear of saying the wrong things.” Providers stated that they understood the importance of connecting with a client but expressed awkwardness and discomfort with the actual interview process.23

Misra and Wallace24 set the framework for culturally appropriateness, categorizing it as a “description for content, research, or interventions that reflect an appreciation of the cultural background and history of the consumers, research subjects, or clients—being designed in accordance with the characteristics and needs of the target audience or population, based on prior information, data, or experiences.” Appreciation comes from the awareness of self and the cognitions to codify experiences previously set forth.24

Defining cultural competency has been complex, as many disciplines have similar concepts of language identifying the core of cultural competence. Cultural and linguistic competency is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communication, action, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Cultural competency is one of the main ingredients in closing the disparities gap in health care. It’s the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but instead enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices, cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Obedin-Maliver et al.,13 stated, in a landmark report, that the median time devoted to LGBT curriculum content in undergraduate medical education was five hours. This reporting was from 176 medical schools in the United States and Canada. Overall 24.2% of the Dean’s reporting for the medical schools reported the overall curriculum coverage as “good” or “very good” on a 5-category Likert scale. Interestingly out of the 132 respondents (or schools), 128 reported teaching medical students to ask patients who they had sex with “men, women or both” during sexual history taking encounters. 95 schools reported teaching students the difference between behavior and identity. No notation was made about gender and identity. The preclinical content that was assessed was reported as taught “interspersed throughout various parts of the curriculum” at 88 schools, “taught in discrete modules dedicated to LGBT content” in 32 schools. Notably, only 35 out of the 132 schools had increased financial resources for LGBT teaching content in their curriculum.13

The value of exploring similarities in patient and provider attitudes, beliefs and expectations through the HLOC assessment (or type of assessment) has strong associations for future research.28

Matharu, et al.29 completed a cross-sectional web based survey of medical students at the University of California; they calculated the attitudes of the medical students towards gay men in civil rights, intimate sexual expression, and traditional roles. In regard to civil rights, the medical students reported few negative attitudes. “Overt disgust towards gay men was infrequent.” Homosexuality was reported as “a natural difference, like left-handedness.” In regards to the intimate sexual expression (men having sex with men), the associations were negative, particularly from the male respondents under the age of 25. Overall, the medical students recognized toughness as a traditional role associated with being a male. These results are unconscious biases that could affect practice and behavior towards patients.26

Steele, et al.,27 researched the influence of provider inquiry about sexual orientation, perceived provider gay positivity, and lesbians’ disclosure of sexual orientation. When physicians are perceived in a gay-positive standard, if the physician questions about sexual orientation, the patient is more likely to disclose their sexual orientation. These predictive associations are resourceful markers for future training. “Disclosure predicted regular health care use” within this sample of lesbians. Noted was the anxiety of “outing” themselves and many lesbians “scoping” out a doctor’s office before going to confirm gay positivity. Provider-related behavior such as using a non-judgmental tone, avoiding assumptions, and using gender-neutral language was noted by the authors as high markers for regular health care use by lesbians.27

In addition, stereotypes held by physicians impact three levels of patient care; patient-level barriers, whereby the beliefs regarding a health condition in an ethnic or racial group may impact disease management and treatment adherence; patient-provider communications, whereby physician communication styles with patients may impact patient responsiveness and engagement with physicians; and system-level barriers, whereby institutional changes are needed to include cultural competency training during medical school training of physicians.28

Overall, the future goal of all measures is to access the diverse nature of providers and how the providers’ knowledge based on cultural competence is not the complete answer in the patient/provider relationship. A grasp of the “power relations of social inequality” is vital in the contextual movement of health inequity to health equity. The ability for “individual knowledge” and “self-confidence” of cultural competence is “not sufficient” for eliminating the social, historical and institutional binds of power in health inequality (Kumas-Tan et al., 2007).

Methods

This purpose of this study is to conduct an online survey of varied health care providers (i.e., physicians, physician assistants, nurse practitioners, nurses, psychiatrists, clinical psychologists, clinical social workers, marriage and family therapists, physical therapists, occupational therapists, recreational therapists, health educators, substance abuse counselors, or other providers) who have had contact with patients in a health care setting within the past six months (i.e., hospital or medical center, emergency room, outpatient clinic, outpatient primary care practice office, private practice, mobile medical van, etc.) in order to determine:

i. their self-ratings of their level of cultural competence in response to a definition of what this entails;

ii. the prevalence of their engagement in cultural competence training, including the number of hours of training, the context of that training (i.e., degree program, work/continuing education, or personal interest), and how they would rate the quality of training they received;

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their ratings of various options for how they might receive any cultural competence training in the future, whether

a) in person training in a workshop, seminar or course,

b) a series of grand rounds,

c) online training or coursework,

d) website based videos codifying training, or

e) independent reading;

iv. their “culturally competent health care delivery” stage of change (i.e., precontemplation, contemplation, preparation, action, maintenance; as per the work of Prochaska & DiClemente), for taking action to be culturally sensitive, culturally competent, and culturally appropriate before taking a new survey designed to also potentially serve as a brief educational intervention;

The study has been delimited to include self-selected volunteer healthcare providers, physicians, physician assistants, nurse practitioners, nurses, psychiatrists, clinical psychologists, clinical social workers, marriage and family therapists, physical therapists, occupational therapists, recreational therapists, health educators, substance abuse counselors, or other providers who have had direct contact during service delivery with patients in a health care setting within the past six months (i.e., hospital or medical center, emergency room, outpatient clinic, outpatient primary care practice office, private practice, mobile medical van, etc.). The study will only include adults age 24 and above who access the survey during the limited enrollment period (i.e., 1-2 months post- Institutional Review Broad approval). As an online study, the participants needed to have Internet access. Another delimitation of the survey is that it was only conducted in English.

Given the self-report nature of the study, and the relatively sensitive nature of the topics addressed, participants’ responses might be affected by social desirability bias. Study findings cannot be generalized beyond the sample of convenience. Volunteers may also have certain characteristics contributing to bias. The proposed study was preliminary in nature, given that relatively little research has been conducted on healthcare providers and their cultural competence with LGBT and MSM patient populations, and the study used a new survey created for this investigation.

A convenience sample of healthcare providers was recruited to screen for eligibility for the study inclusion criteria directly on the Survey Monkey link www.surveymonkey.com/s/SurveyforProviders. The survey data was imported from Survey Monkey to IBM SPSS Statistics 20.0 and cleaned for analysis. A total of 657 individuals responded to the social marketing campaign to participate in the study survey. Out of the 657, a total of 301 completed the survey to the end but only 208 completed the survey and met inclusion criteria. Survey Monkey met the immediate needs of an IRB, researcher, and participant by offering streamlined programming, recruitment ease and data collection options.

Recruitment occurred exclusively online via social networking resources. Eligible participants included all types of healthcare providers, over the age of 24, who had direct patient contact over the past six months. Participation was limited to the first 200 healthcare providers—whether physicians, physician assistants, nurse practitioners, nurses, psychiatrists, clinical psychologists, clinical social workers, marriage and family therapists, physical therapists, occupational therapists, recreational therapists, health educators, substance abuse counselors, or other providers.

The use of multiple professional listservs, email databases, Face book, Twitter, LinkedIn and other online resources, allowed a diverse set of respondents to become informed and potentially participate in the research study. Exclusive online recruitment occurred by resourcing healthcare oriented Face book, Twitter and LinkedIn accounts with informational statuses (notifications). There were over 1,000 Face book posts, over 2,000 Twitter tweets, and about 250 LinkedIn posts. It is often anecdotally noted that Face book is “for bonding” and Twitter is “for bridging”. Within the recruitment for this study, the bridging occurred within Twitter utilizing retweets of the study by Dan Savage, Kate Bornstein and a number of other prominent LGBT activists.

This population is categorized as a convenience sample of participants, due to the self-selected and voluntary nature of their inclusion. This type of population offered a wide range of participants to participate; however, the information is not generalizable to every healthcare professional. This population offered historical insight into changing mores in training, the ability to change, and predictors for cultural competency healthcare service delivered to sexual minorities.

Results

A total of 657 participants began the online survey, 301 completed less than 80% of the survey, and 208 participants completed greater than 80% of the online survey. The majority, 65.9% of the participants reported their gender as female, 30.8% as male, and 3.4% transgender. The mean age was 41.16, with a standard deviation of 11 years. The sexual orientation was diverse, with a representation of 59.6% heterosexual respondents, 15.9% gay respondents, 1% identified as MSM, 14.7% identified as lesbian, 11.1% identified as bisexual, and 5.8% identified as other. The relationship status reported as single was 28.4%, married as 46.6%, separated as 1.0%, divorced as 4.3%, widowed as .5%, in a domestic partnership as 9.6%, and living with a significant other as 9.6%. The race analysis represented a large majority 72.1% as White/Caucasian/European American, 8.2% as Black/African American, 6.7% as Hispanic/Latino, 5.3% as Asian, 1.9% as American Indian/Alaska Native, .5% Native Hawaiian/ Pacific Islander, .5% Arab American/Middle Eastern, and 4.8% as Other/Mixed Race.

The yearly income was reported as $10,000 to $49,999 for 17.3% of the sample, $50,000 to $99,999 for 33.7% of the sample, $100,000 to $199,999 for 34.1% of the sample, $200,000 to $299,999 for 8.7% of the sample, $300,000 to $399,999 for 3.4%, $400,000 to $499,999 for 1.4% of the sample, $500,000 to $799,999 for .5% of the sample and $800,000 or more for 1% of the sample. The mean was 2.58, which indicates $158,000 as a mean yearly income and with a standard deviation of 1.23. The race analysis represented a large majority 72.1% as White/Caucasian/European American, 8.2% as Black/African American, 6.7% as Hispanic/Latino, 5.3% as Asian, 1.9% as American Indian/Alaska Native, .5% Native Hawaiian/ Pacific Islander, .5% Arab American/Middle Eastern, and 4.8% as Other/Mixed Race.

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Respondents reported the characteristics of the treatment populations. The majority of healthcare providers who responded to
this study reported high incidence of engaging with Men (94.7%), Women (95.2%), Adults (98.1%), Seniors (89.4%), Whites (97.1%), Blacks (96.6%), Hispanics (94.2%), High SES (93.2%), Middle SES (96.6%), Low SES (96.6%), Gay (92.3%), Bisexuals (88.9%), and Lesbians (92.3%) patient populations. Interestingly, lowest numbers of engagement with children at (64.9%) have been reported, with Transgender (66.8%), and with MSM (74%).

Cultural competence is defined as “An awareness of self and one’s own value systems; And an understanding of culture and its role as a factor in health and health care; A sensitivity to cultural issues for each patient; And an understanding and ability to use specific methods to deal effectively with issues in interacting with individual patients, their families, members of the health care team and the wider community” (Cohen & Goode, 1999). The self-ratings in response to this definition were fair at 4.8%, Good at 18.3%, Very Good at 49.5%, and Excellent at 27.4%. The cultural competence self-rating mean was 6 and the standard deviation was .808 suggesting the sample had a very good self-rating for cultural competence.22

For scores ranging from 0 to 5, the prevalence of their engagement in cultural competence training was (score 0) 0 hours at 13%, (score 1) 1 to 5 hours at 13.5%, (score 2) 6 to 10 hours at 15.9%, (score 3) 11 to 20 hours at 16.3%, (score 4) 21 to 30 hours at 6.7%, (score 5) 31 to 40 hours at 34.6%. For number of hours of cultural competence training, the sample mean was 2.94 and the standard deviation was 1.82 (Min 0, Max 5) suggesting the sample was closest to averaging 6 to 10 hours of training.

The context of that cultural competence training (i.e., degree program, work/continuing education, or personal interest), and how they rated the quality of training they received was reported as 47.6% for a degree program, 67.8 for a work/continuing education program, and 42.3% for personal interest. Respondents could select a multitude of responses. They rated the quality of training they received at .5% for Very Poor, 1.4% for Poor, 17.8% for fair, 47.6% for good, 19.7% for Excellent, and accounting for 13.0% for those who reported no training. The sample’s mean rating of the quality of cultural competence training they had received was 3.97 (Min 1, Max 5, SD=.741), or closest to the rating of Good. See Table 1.

What was their “culturally competent health care delivery” stage of change precontemplation, contemplation, preparation, action, maintenance; for taking action to be culturally sensitive, culturally competent, and culturally appropriate before taking a new survey designed to also potentially serve as a brief educational intervention?

The (N=208) respondents categorized their “culturally competent health care delivery” stage of change as follows: Precontemplation (score 0) 0 hours at 13%, (score 1) 1 to 5 hours at 13.5%, (score 2) 6 to 10 hours at 15.9%, (score 3) 11 to 20 hours at 16.3%, (score 4) 21 to 30 hours at 6.7%, (score 5) 31 to 40 hours at 34.6%. For number of hours of cultural competence training, the sample mean was 2.94 and the standard deviation was 1.82 (Min 0, Max 5) suggesting the sample had a very good self-rating for cultural competence.22

The ratings reported by the (N=208) respondents on the emergent survey that codifies principles and standards/guidelines for delivering health care to the LGBT and MSM populations. The minimum response was 1 and the maximum response was 5 (i.e., 1=Very low, 2=Low, 3=Moderate, 4=High, 5=Very High).

In regard to their knowledge, ability, preparation, and value are as follows:

i. For knowledge (personal level of knowledge for enacting the principles/standards/guidelines) with an n=203, the mean was 4.08, with a standard deviation of .67 (Min 1.96, Max 5)-suggesting the sample had a good level of knowledge.

ii. For ability (personal ability/skill level for enacting the principles/standards/guidelines) with an n=203, the mean was 4.00, with a standard deviation of .67 (Min 2.06, Max 5)-suggesting the sample had a good ability level.

iii. for preparation (education and training having prepared them for enacting the principles/standards/guidelines) with an n=203, the mean was 4.00, with a standard deviation of .67 (Min 2.06, Max 5)-suggesting the sample had between fair to good preparation.

iv. For value (attitude (value) regarding the importance of the training of future professionals including preparation for enacting the principles/standards/guidelines) with an n=204, the mean was 3.47, with a standard deviation of .86 (Min 1.06, Max 5) suggesting the sample had between fair to good preparation.

The overall scale (Global Cultural Competence) had excellent internal consistency (Cronbach’s Alpha=.993) Within the four domains of the new scale, internal consistency was as follows:

### Table 1 Cultural competency self-rating characteristics & training vita

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<th>Cultural Competency Self-Rating Characteristics &amp; Training Vita</th>
<th>N</th>
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<tr>
<td>Fair</td>
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### Cultural Competency Hours Completed

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<td>Personal Interest (N=208)*</td>
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The demographic questions had commentary by Researcher Eli Green “my guess is that if trans-sensitive providers are filling this out or reading the results, there may be some backlash. I realize that is hard to do much about when you are basing the research on other people’s work. I know it is a challenge with research language, etc., is hard to do much about when you are basing the research on other. I realize that there may be some backlash. I realize that is hard to do much about when you are basing the research on other people’s work. I know it is a challenge with research language, etc., but I do know a lot of folks would get to the 42% mark and stop because of the binary appearance.” The 42% was the area that denotes LGB, and is not inclusive of LGBT, based on McNair and Hegarty’s work.

Interestingly, lower numbers of engagement with children at 64.9% have been reported, with Transgender 66.8%, and with MSM 74%. The lower exposure to children may be due to adult versus child clinic settings, while the Transgender and MSM populations are inherently hidden, so the lower reported numbers could possibly be attributed to that. This area, capturing a glimpse of what the healthcare provider sees, could be interpreted as binary; future use of this assessment tool should be more inclusive of ages, ethnicities, orientation, and identity.

For the highest or excellent-rated source of future cultural competency training, in-person training in a workshop, seminar or course was rated highest at 49.5%, followed by a series of grand rounds devoted as 23.1%, online training or coursework rated third at 19.2%, website based videos codifying training at 13.9%, and independent reading last at 14.9%. Noteworthy is the 13.9% open to website based videos codifying training.

For taking action to be culturally sensitive, competent, and culturally appropriate, the vast majority (71.2%) were in Maintenance, categorized as “I have been thinking about these issues, and I have been taking action that reflects consideration of these issues for more than 6 months”. The sample’s Pre-Survey Stage of Change (N=208) mean was 4.32 (between action and maintenance, but closest to action) and the standard deviation was 1.21 (Min 1, Max 5). In comparison, in Bonvicini and Perlín, in a review of the scientific literature, found the opposite in regards to clients and lesbian and gay patient communication channels. Within the studies they reviewed, the overwhelming body of evidence demonstrated a lack of ability to be culturally competent in the care of lesbians and gays; this reflected deeply in discrimination, bias, and structural barriers to competent care.

The commentary from both the unsolicited respondents and the requested researchers/health providers informed the principal investigator of the great need for assessing the delivery modality. It has been documented that medical school training lacks a solidified and thorough sexual minority-training curriculum. Patients have documented in dozens of dozens of qualitative measures of the inadequacies of healthcare providers. The health disparities documented within sexual minority patient populations tells a rich story of health inequity. Providers are at the one end of the healthcare delivery spectrum; blaming the provider for lack of knowledge, abilities, and skills is blaming the victim. Assessment of their knowledge, abilities, and skills, and the appropriate learning modalities is the beginning of creating an impactful curriculum for healthcare providers.

This survey tool is the beginning of a curriculum creation and offers assistance in guiding standards, measuring assessment, and oversight. The long-term mission of this study is to gain a better understanding of distinct sexual minority patient populations and provider relationship dynamics and the contextual factors that shape them; in order to develop a curriculum to improve the cultural competence of healthcare providers for providing standard-based healthcare services for sexual minorities, while reducing health disparities and increasing health equity.

First, with the vast majority (71.2%) already in maintenance, the sample as a whole had “nowhere to go” or no room for progressive movement, noting the privilege of time and experience. Second, of interest were those in the sample just in the early stages of pre

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of disease and the analysis of the conclusion hosts a comprehensive
definition of cultural competence.

Affirmation for LGBT clients in a critical adaptive response for
practitioners recognizing the overt social injustices that have occurred
historically as personal injustices and responding in a positive and
accepting manner can dramatically improve patient engagement. The
awareness of engagement in cultural competence can be identified by
the affirming response of the practitioner.

Aspects of this study’s design limit the generalizability of its
findings, such as the use of a convenience sample. A future nationally
representative sample within grant-funded research would address this
limitation. Such a comprehensive assessment of a more diverse sample
of healthcare professionals (i.e., type of setting, various professions,
diverse race/ethnicities) would allow for better generalizability; in
addition, there could be representative sub-samples of professionals
(i.e., medical doctors, nurses, psychologists, social workers) for
comparison with regard to their knowledge, ability, preparation, and
value placed on cultural competence training. Recruitment could have
been longer or more specific as per such designated sub-populations,
yet the research was not funded.

Also, ideally, expert reviews could have been incorporated before
the study launch, allowing for an enhanced tool being piloted and
evaluated. Yet, again, busy professionals did not respond quickly, and
lack of funding necessitated a concentrated research time-period.

Further, the sample attracted to the study on cultural competence
or LGBT and MSM may have been more competent (i.e., over 70%
in the maintenance stage). Future research could ensure that there is
greater representation of those in the less advanced stages (i.e., pre
contemplation, contemplation), or use a sample with proportional
representation of subjects in all the stages.

Future research could investigate the characteristics of those
who dropped out; for example, were they of a particular race or
professional background? Noteworthy is how no demographic data
is collected before completion of the informed consent or signing of
the participant’s rights-limiting research in this area. It is possible
that busy hospital staff faced problems with computers timing out
before they could complete the survey, especially if they had to stop
to perform hospital duties. Others may have felt uncomfortable with
the questions, perhaps facing what they did not know, and dropped
out. Some might relate this to the length of the survey.

Regarding survey length and survey development, this is where
some researchers might recommend factor analytic studies to identify
items for elimination. However, the matter is worthy of debate,
including the resultant limitations.

Another view is that the study has produced a new tool that
serves the purpose of a brief intervention (i.e., especially for those
in pre contemplation and contemplation for taking action to become
culturally competent) which is vital for improving the level of
cultural competence among providers; and, for improving the care of
the LGBT population so as to reduce inequities in service delivery
(i.e., discrimination, stereotyping) that may be contributing to health
disparities. This matter is seen as urgent, over-riding the concept of
the tool being revised to take less time to complete. Forty-five minutes
for a brief intervention shown in this study to promote movement
toward taking action to become culturally competent is deemed a vital
contribution to the field of health equity—over and above the goals
of other researchers to standardize the measure development process; valuing a particular path to research tool development over the health disparities suffered daily by members of the LGBT patient population is viewed as misguided and insensitive. Furthermore, how is one to decide upon which of the following kinds of items should be removed from the survey to shorten cultural competence training?

A. Providing treatment with the awareness that not all patients identify with their natal sex (gender at birth), avoiding assumptions that could serve to offend or alienate some PATIENTS —such as the transgender, or youth still coming to terms with or developing their identity.

B. Providing treatment while being aware of and responsive to how PATIENTS may experience domestic violence with their partners, yet attempt to conceal it to avoid shame and stigmatization.

C. Providing treatment while being aware and responsive to how PATIENTS may have concerns involving the legal recognition of their relationships with their partners (i.e., marriage, domestic partners, etc.), as well as legal recognition of the role of non-biological parents raising children in their families; and how youth raised by PATIENTS may be coping with issues of “divorce” and separation from a parent to whom they remain attached.

D. Communicating in interviews so as to be inclusive of the possibility that a child, adolescent, or adult patient has a non-biological parent, or two fathers, or two mothers, as well as a non biological/extended family.

Are thoughtful researchers-practitioners-LGBT patient advocates to allow a factor analytic study to determine which of the above topics should not be included? Or, should one value a comprehensive 45-minute brief intervention provided by a research tool that also collects data on the domains of knowledge about that item, ability to perform the behavior, preparation and training to perform the behavior, and rating of the importance of future training covering that item? Despite any debate on the matter, the present researcher endorses the need for comprehensive training that is brief, as embodied in the new research tool. Moreover, the research consistently found that one of the best predictors of being in an action or maintenance stage for working toward becoming culturally competent was the number of hours of training; the more hours, then the higher the level. Recall the main study implication that training programs should increase hours of training; the more hours, then the higher the level. Recall the researcher’s vision of creating a tool that serves as a brief intervention. Furthermore, it may be argued that a tool rooted in an extensive review of literature has face validity to compliment the excellent internal consistency found in this study.

Despite the limitations and decisions to be made regarding pursuing funding and engaging in further research, this study has made valuable contributions to the literature. A tool has emerged that can serve both as a brief intervention and valuable research purposes—revealing levels of knowledge, ability, preparation, and value, as well as pre-survey stages of change. Even as much research maligens self-ratings, and this is another limitation, it may be said that consumers of their education (i.e., on cultural competence) may be the best to rate and judge it, and to estimate the number of hours of training they have received. Some data is too complex to be collected via triangulation. The researcher included a measure of social desirability and ran regressions that controlled for social desirability-finding near exact replication of all patterns of predictors for five separate regressions (i.e., predicting knowledge, ability, preparation, value, and pre-survey stage of change). In conclusion, despite many potential limitations, the researcher can claim a valuable contribution to the literature.

The survey has a key role to play in the training movement for healthcare providers to attain cultural competence for working with Lesbian, Gay, Bisexual, Gay (LGBT) and Men who have Sex with Men (MSM). Our healthcare system has been monopolized by inadequate cultural competence trainings within the walls of biased homophobic institutions. Indeed, even some researchers have devalued the urgent needs of LGBT patient populations, while valuing other agendas, such as standards for research tool development. Further, the intersection of race and sexual orientation enhances the risks of inadequate healthcare reflecting discrimination and stigmatization.

How will future healthcare providers in the United States be trained for addressing the specific needs of the LGBT and MSM patient populations, given the risk of poor health care service delivery contributing to health disparities? This survey and the implications discussed suggest a roadmap to future training. In particular, the planned textbook may provide a new road for training.

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